What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

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BEATING AGONGO'S 'GONG-GONG'

The Upper-East region is the most advanced in CHPS. *What works?…* caught up with the Regional Director of Health Services, Dr. Erasmus Agongo, and put the question directly to him, ' what's your game plan?'

WW: How have health indicators changed since you have been in charge here?

Dr. Erasmus Agongo (AG): A lot. Service coverage has significantly improved. In 1994/95 immunizations coverage for instance was around 40%. Today it ranges between 70-90%. Disease surveillance has so significantly improved that epidemic-prone diseases are now very well known. Public education has also improved remarkably. OPD attendance, which hovered around 20-30% in 1994/95, has risen to 50%. But this is not necessarily because I have been in charge. These achievements are significant, if you consider the fact that we have to contend with consistently decreasing numbers of health personnel.

WW: What are the obstacles to doorstep health care?

AG: The main thrust of the Community-based Health Planning and Services (CHPS) is the health worker placed in the community to offer door-to-door services. Unfortunately the Community Health Nurses (CHN) who are suitable for the CHPS programme are seriously lacking. The number of CHN in this region for instance has decreased by 50% since 1995. The human resource is the critical factor in community-based health service delivery. The other thing is the idea of bringing people from outside to train staff for CHPS who may not be conversant with how the concept works. It kills local initiative. Those who are most qualified to train people in 'community entry and mobilisation' for instance are the Navrongo Health Research Centre. It is they who should be providing that technical support needed to get CHPS going.

Agongo: no outside interference in the CHPS process

WW: How about the concept of the "lead districts," how is it helping?

AG: The "lead districts" idea has impacted negatively on the CHPS process in this region. We adopted findings of the Navrongo Experiment in 1999 even before the nation adopted CHPS. This was done in the presence of the Regional Minister, the Regional Health Management Team, the District Health Management Team at a conference addressed by Navrongo. All the districts agreed that CHPS was the way forward and went ahead to start in the first year. Many were slowed down by lack of health personnel. This was the problem with Builsa district. Bawku West put a nurse in one community but when she went to school the programme stalled. I am glad to say a new nurse has been sent there and the programme is running smoothly again.

WW: Why shouldn't selected districts test CHPS out so lessons can be pick from them?

AG: In the first place the district should not be the focus of CHPS. The focus is the community. The "lead districts" concept takes a lead district from every region, two lead sub-districts from every district and two lead communities from every sub-district to implement CHPS. What happens when you have districts or communities outside these lead districts that are ready to take off with CHPS? They will have to wait because they are not even included in training programmes! Do you get my point?

WW: What is your point?

AG: I am saying give capacity to all districts so that they can implement CHPS at the rate that resources allow. CHPS is not a programme for health workers alone. It involves the community, the district assembly and the traditional authority. You need to bring the district assembly on board and constantly keep them aboard because they have the resources to put up the structures or contact NGOs that can assist. Under the "lead districts" concept, CHPS is an entirely Ministry of Health affair.

WW: In spite of the difficulties, Upper East is the most advanced CHPS district, what's your secret?

AG: The secret is that both the health worker and the community members are enthusiastic about CHPS. The district assemblies are also committed. We want our nurses' dwelling compounds to be more decent than the ones in Navrongo. All the compounds should also be provided with electricity or solar energy. These are to motivate the nurse to stay in the community but the communities are poor and cannot afford these necessities. Apart from communal labour the community's major contribution so far is the patronage of services.

WW: CHFP was not directed at CHPS, remember?
AG: It was directed at family planning, but if you look at what the nurses are providing, it is more like family health services and that includes family planning.
WW: So what tells the CHFP and CHPS apart?
AG: CHFP was a research project to acquire generalisable knowledge whereas CHPS is a programme to expand health service to communities. The components are the same. There are only some modifications.
WW: What for instance can be modified?
AG: Under CHPS CHO will be doing more of first aid than was the case under experimental conditions. The regularity of compound visits could also vary depending on the size of the area of coverage. The number of people at a CHPS station could also vary depending on the size of the community. In very large communities the nurses may be more than one to share responsibilities. Some nurses' residence may be fitted with delivery beds so that mothers can be safely and conveniently delivered of their babies. CHPS can also be modified to fit an urban setting. Nurses may not stay in a community but could be given responsibility to oversee health there as the community's CHPS officer. As such she will be able to organise community meetings just like it happens in rural settings. These are possibilities that deserve serious consideration.
WW: What is needed to make CHPS sustainable?
AG: CHPS is sustainable if government makes a commitment to pay and motivate the staff to stay where they are posted. The bill is manageable if you look at what is spent on other things. CHPS officers should be given the needed logistics to work. Transport is particularly essential. Durable CHC structures are essential.
WW: What are you doing to make CHPS sustainable in the Upper-East?
AG: First of all we want to make the communities own CHPS. We have mapped out every district into CHPS zones and asked them to come out with a CHPS implementation plan. We want the communities to take the initiative. If they have a sense of ownership of the process, they will keep working at it till they get it right. Our role is to facilitate the process and pay regular monitoring visits to CHPS areas. CHPS has consistently featured in our annual review seminars. This is to emphasize the importance of programme.
WW: How many communities can you say are implementing CHPS in the Upper East region now?
AG: Available reports indicate that almost every community is in for CHPS but these are at various stages of the process. There are over 50 zones implementing CHPS. We urge people on but we keep insisting that CHPS is not to put a nurse in the community to run a clinic. CHPS is a work plan that makes the health worker part of the community.
WW: You don't seem to be making good use of Navrongo?
AG: There is a lot of interference from outside that makes it difficult to tap into Navrongo's experience. Bawku West has been able to contact Navrongo directly and they are doing fine. A lot of things need streamlining. The people started with Navrongo and suddenly they have to deal with a different team. So CHPS is seen as a different programme altogether. The idea of training trainers for the region who will then train others in the district is not helpful. It has a lot of implications. First of all each district has its peculiar problems. Secondly nurses would not appreciate their colleague nurses coming to train them. It is different when nurses are taken from across the district and trained. We need to be sensitive about some of these things. Basically that has been the reason why we have not made good use of the facility in Navrongo. But henceforth, more and more districts will be coming especially so when it does not cost anything to tap Navrongo's experience.
WW: What can Navrongo do to speed up the process?
AG: One thing is to work to improve the information system of CHPS. The monitoring team from the Volta Regional Health Administration is doing a good job by noting down the processes. I am also encouraging my people to take note of the outputs—how many antenatal patients seen in CHPS areas, level of immunizations coverage, number of sick people seen. If you only look at the process indicators it will not make people focus clearly on what their goals are. Navrongo can also lobby people to come and support CHPS in the country. Then there would always be new ideas and the dissemination of new ideas is helpful.
WW: Do the communities really know what is going on?
AG: Yes, they do. They may not call it CHPS but they see that health has really been brought to their doorstep. That is why other communities are now clamouring for CHPS. With a good number of nurses we should have been far away in CHPS.
WW: Any immediate plans to raise the numbers of health personnel needed to run CHPS?
AG: Our hope is on the Day Community Health Nurses Training School that Navrongo is trying to establish. The Ghana Health Service has also seen the need and has tried to increase intake in the existing training schools. Products of the Kintampo Training School could also be candidates for CHPS. So there are two ways out; increasing intake and opening new schools. The volunteer system should also be strengthened to support the nurse in the community.

Send questions or comments to: What works? What fails?
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